MDR Tracking Number: M5-04-1082-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-12-03.

The IRO reviewed work hardening program and FCE from 7-24-03 through 8-5-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 4-12-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice. Neither party submitted original EOB's for DOS 7-21-03, 7-22-03, and 7-23-03 that the respondent denied after reconsideration. Therefore, review for these DOS will be per the 1996 *Medical Fee Guideline*.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
1-31-03	97750 x 3 units	$148.35	$0.00	N	$43.00 ea 15 min	Rule 133.307(g)(3) (A-F)	The requestor failed to submit relevant information to support documentation criteria and delivery of service per this rule. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
6-13-03	97010 97014 97530 x 3 units 97110 x 3 units	$12.65 $17.25 $80.50 $120.75	$0.00	No EOB	$11.00 $15.00 $35.00 ea 15 min $35.00 ea 15 min		Relevant information supports therapeutic activities only. Recommend reimbursement of $35.00 x 2 units = $70.00. 97110. See **RATIONALE** below.
7-21-03	97545WHAP 97546WHAP	$128.00 $256.00	$0.00	O	$64/hr for CARF		Relevant information supports delivery of service for 5-½ hrs. Recommend reimbursement of $64.00 x 5.5 hrs = $352.00.
7-22-03	97545WHAP 97546WHAP	$128.00 $256.00	$0.00	O	$64/hr for CARF	Rule 133.307(g)(3)(A-F)	Relevant information supports delivery of service for 5-½ hrs. Recommend reimbursement of $64.00 x 5.5 hrs = $352.00.
7-23-03	97545WHAP 97546WHAP	$128.00 $192.00					Relevant information supports delivery of service for 4 hrs 45 min. Recommend reimbursement of $64.00 x 4.75 hrs = $304.00.
TOTAL		$379.50	$0.00				The requestor is entitled to reimbursement of $1,078.00.

RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

The above Decision is hereby issued this 14th day of May 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 6-13-03 through 8-5-03 in this dispute.

This Order is hereby issued this 14th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

April 6, 2004

Re: IRO Case # M5-04-1082-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent

review. In

addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient reported injury in ___ when he was wrapping skids and reported acute onset of pain in his right leg and hip. He was evaluated on 11/11/02 and was treated with pain medications and physical therapy. A 1/2/03 MRI of the lumbar spine revealed a right paracentral disk protrusion at L5-S1, displacing the nerve root. A functional capacity evaluation was performed on 6/17/03. The patient participated in a work hardening program beginning on 7/14/03.

Requested Service(s)
Work hardening program, FCE 7/24/03-8/5/03

Decision
I disagree with the carrier's decision to deny the requested work hardening and evaluation.

Rationale
The patient had completed a six-week physical therapy program, but he was still unable to perform the activities required for his job. The patient's deficits were demonstrated in an FCE on 6/17/03, which rated the patient at a light work level. His job required a medium physical demand level. His activity tolerance was inadequate to perform lifting, carrying, kneeling, and crouching requirements. Psychological screening also demonstrated a need for psychological intervention as part of the multidisciplinary work hardening program. The patient was able to return to work at the normal physical demand level following completion of the work hardening program.
The 8/5/03 discharge FCE at the completion of the work hardening program was necessary to demonstrate the patient's ability to return to work.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.